APPENDIX C

AIDS WAIVER CRITERIA & NUTRITIONAL ASSESSMENT

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TABLE OF CONTENTS

MEDICAID AIDS WAIVER SERVICES PRE-SCREENING SERVICE PLAN

Recipient Name: _____ Medicaid #: _____

I. SERVICE NEEDS: Note services currently received & who is providing & services needed & potential provider

Service Area	Currently Received	Provider	Service Needed	Refer To Provider
Activities of Daily Living				
Housekeeping				
Living Space				
Meals/Nutritional Supplements				
Shopping/Laundry				
Transportation				
Supervision				
Medicine Administration				
Financial				
Legal Services				
Child Care				
Foster Care				
Dental				
Counseling/Therapy				
Substance Abuse Treatment				
Health Education				
Support Groups				
Attendant Services				
Home Health				
Rehabilitation				
Outpatient Clinic				
Equipment/Supplies				
Physician				
Hospice				
Laboratory Service				
Other				
Other				

II. MEDICAID AIDS WAIVER SERVICES: The following services are authorized to prevent institutionalization

☐ CASE MANAGEMENT Provider: _____ Date Referred: _____

☐ NUTRITIONAL SUPPLEMENTS Physician's Order Attached ☐ Authorization Form to Recipient ☐

☐ PERSONAL CARE Provider: _____ Date Referred: _____

☐ RESPITE CARE Reason Requested: _____

Provider: _____ Type of Respite: ☐ Aide ☐ LPN ☐ RN Date Requested: _____

☐ PRIVATE DUTY NURSING Provider: _____ Date Referred: _____

☐ CD SERVICES Facilitator Agency: _____ Date Referred: _____

I have been informed of the available choice of providers and have chosen the providers noted above:

Medicaid Recipient	Date	PAS Staff	Dater

DMAS-113B (rev 1202)

NUTRITIONAL STATUS EVALUATION FORM

(This form is required for the provision of enteral nutrition and must be completed as part of a face-to-face nutritional evaluation by a physician, registered nurse, or dietian. Re-evaluations for enteral nutrition via this form are required every 6 months. Instructions for completion are on the reverse side of this form.)

A. PATIENT INFORMATION

Name _____ Date of Birth: _____

Social Security Number: _____ Medicaid Number: _____

B. DATA ELEMENTS

Height: Please complete either a or b below.

a.	Height in inches	b.	Length in inches

Weight: Please complete a, b, and c below.

a.	Current weight in pounds OR		
_____ mid-arm circumference _____ triceps skin fold	Mid-arm circumference (in centimeters) and triceps skin fold thickness 9in millimeters). These measurements are to be used for patients who cannot be feasibly weighed. If known, add measurement for mid arm muscle circumference (in centimeters): _____		
b.	Ideal body weight	c.	Previous or initial weight (if available)

Formula Tolerance: Please check all that apply to the current condition of the patient

a.	Hydrated?	e.	Increased gastric residuals?
b.	Nausea?	f.	Constipation?
c.	Vomiting?	g.	Diarrhea?
d.	Gastric Reflux?	h.	Not currently receiving a formula

Tube or Stoma Site Assessment: Please check all that apply.

a.	Gastrostomy tube?	e.	Stoma site red or irritated?
b.	Nasiogastric tube?	f.	Tube flushes easily?
c.	Other tube?	g.	Fiberous tissue growth?
d.	Leakage present?	h.	Patient complaints?

Date of last tube change: _____

C. THIS NUTRITIONAL SUPPLEMENT IS THE _____ SOLE OR _____PRIMARY SOURCE OF NUTRITION FOR THIS PATIENT (Please check one only; reference instructions on the reverse side of this form)

D. PROGRESS STATEMENT: Base on this evaluation and the plan of care, the patient is (circle one)

1. Stable 2. Progressing toward goal 3. In need of further evaluation

E. COMMENTS

F. PHYSICIAN'S ORDER FOR NUTRITIONAL ASUPPLEMENT: Order must include all the following information:

Begin service date (for this certification period) _____

Category or specific supplement ordered _____ Route of administration _____

Caloric order per day _____ Calories per can/pkg _____

G. WOMEN, INFANTS AND CHILDREN (WIC) PROGRAM COVERAGE (For children under age 5)

Recipient receives _____ cans of _____ type of formula through WIC. There are _____ calories per can of this type of formula, _____ additional calories are required to meet the recipient's needs as prescribed in section F above.

H. ASSESSOR INFORMATION:

Name Title Date

DMAS-115 revised 10.99

NUTRITIONAL STATUS EVALUATION FORM (DMAS-l15)

Instructions for Completion

Coverage of enteral nutrition which does not include a legend drug is limited to when the supplement is the sole form of nutrition (except for individuals authorized through the Technology-Assisted or AIDS Waiver or through EPSDT where the supplement must be the primary source of nutrition), is administered orally or through a nasogastric or gastrostomy tube, and is necessary to treat a medical condition. Coverage of oral administration does not include the provision of "routine" infant formulae.

PATIENT INFORMATION

Enter complete, name, date, of birth, social security number, and Medicaid Number.

B. DATA ELEMENTS

- Height (or length for pediatric recipients);
- Weight: a) either give a current weight or, if unobtainable, must provide mid-arm circumference and triceps skinfold test data. b) Ideal body weight should be recorded from the Weight Status Worksheet. c) For initial assessments, indicate the patient weight Loss over time;
- Formula tolerance (e.g., is the patient experiencing diarrhea, vomiting, constipation). This element is only required if the patient is already receiving a supplement;
- Tube or stoma site assessment, as applicable.

C. PRIMARY OR SOLE SOURCE OF NUTRITION

Sole source means the individual is unable to handle *(swallow* or absorb) any other form of nutrition. Primary source means the nutritional supplements *are* medically indicated for the treatment of the recipient's condition, if the recipient is unable to tolerate nutrients. The patient may either be unable to lake any oral nutrition or the oral intake that can be tolerated is inadequate to maintain life. The focus must be the maintenance of weight and strength commensurate with the patients a condition.

D. PROGRESS STATEMENT

Circle *(ONE*)* appropriate progress statement (For AIDS Waiver recipients, this section is not applicable and may be left blank)

E. COMMENTS

If the client receives nutrition orally or via any other means not addressed on the form, the route of administration must be noted here. This section may also be used to record any other pertinent observations and/or recommendations about the client's nutrition.

F. PHYSICIAN ORDER FOR NUTRITIONAL SUPPLEMENT

This Section must be full*y* completed in order for the provider of the enteral nutrition to receive reimbursement. The physician's order for all programs must be documented on the DMAS 352 form, Certificate of Medical Necessity (CMN).

G. WOMEN. INFANT AND CHILDREN (WIC) PROGRAM COVERAGE

Complete this section for recipients under age five. The DME provider must have documentation Sn the Women, Infant, and Children Supplemental Food Program (WIC) regarding the extent of coverage of nutritional supplements available through V/IC. Medicaid will only reimburse the DME provider for the portion of the recipient's total caloric order (per the DMA S-115 form, section F) that is not covered *by W.*IC.

H. ASSESSOR INFORMATION

The forms must be competed by a physician, registered nurse, or dietitian. The person completing the form must sign and date the form here. The DMAS-115 must be signed and dated by the assessor (physician, registered nurse, or dietitian) within 60 days of the DMAS-115 begin service date; otherwise, the DMAS-115 will become valid an the date that the form is signed by the assessor.

A copy of the Nutritional Status Evaluation Form, and a copy of the manufacturer's / Supplier's. Invoke must be attached to the HCTA-1500) when billing for HCPCS codes B4154 and B4155.